YOUTH & DRUGS

AN EDUCATION PACKAGE
FOR PROFESSIONALS

WORKBOOK

UNIT • 3

Identification

Health and Welfare Canada
Santé et Bien-être social Canada

ARF Addiction Research Foundation
Fondation de la recherche sur la toxicomanie

Partners in
canada's drug strategy

Overall guidance for the development of the curriculum materials was provided by the Steering Committee:

Helen Annis, Ph.D. **(Chair and Project Director)**
Peter Bohm, Ph.D.
Dick Boudreau, M.A., M.Ed.
Grant Lowery
Donald Morgan, M.A.
James Rankin, M.D.
Judi Stevenson, M.A. **(Project Coordinator)**
Elsbeth Tupker, M.S.W. **(Content Specialist)**
Graham Turrall, Ph.D.

With the assistance of Project Team members:

Tony Caines
Gwen Carroll
Virginia Carver
Gloria Chaim
Doug Chaudron
Maeve Connell
Christine Davis
Jill Elliot
Bob Finlay
Betty-Anne Howard
Dennis Long
Michael McGuigan
Kathleen Michael
Don Pierson
Marion McIntosh
Barry Sisson
Bob Tremble
Darryl Upfold

With additional thanks to:

Heather Campbell
Catherine Cragg
Mary-Lynn Fulton
Leslie McAfee
Gail McIntyre
Twila Plant

All the reviewers, both inside ARF and elsewhere, who contributed so thoughtfully to this package
Provincial Contacts of the Education and Training Working Group of Canada's Drug Strategy, Health and Welfare, Canada

Designer: Marg Yeo
Educational Advisor: Arlene Zuckernick

This project was jointly sponsored by the Addiction Research Foundation and the Education and Training Working Group of Canada's Drug Strategy, Health and Welfare, Canada.

YOUTH AND DRUGS:
AN EDUCATION PACKAGE FOR PROFESSIONALS

UNIT 3:
IDENTIFICATION

WORKBOOK

Editor: Elsbeth Tupker, Addiction Research Foundation
Writer: Judi Stevenson, Minerva Educational Productions

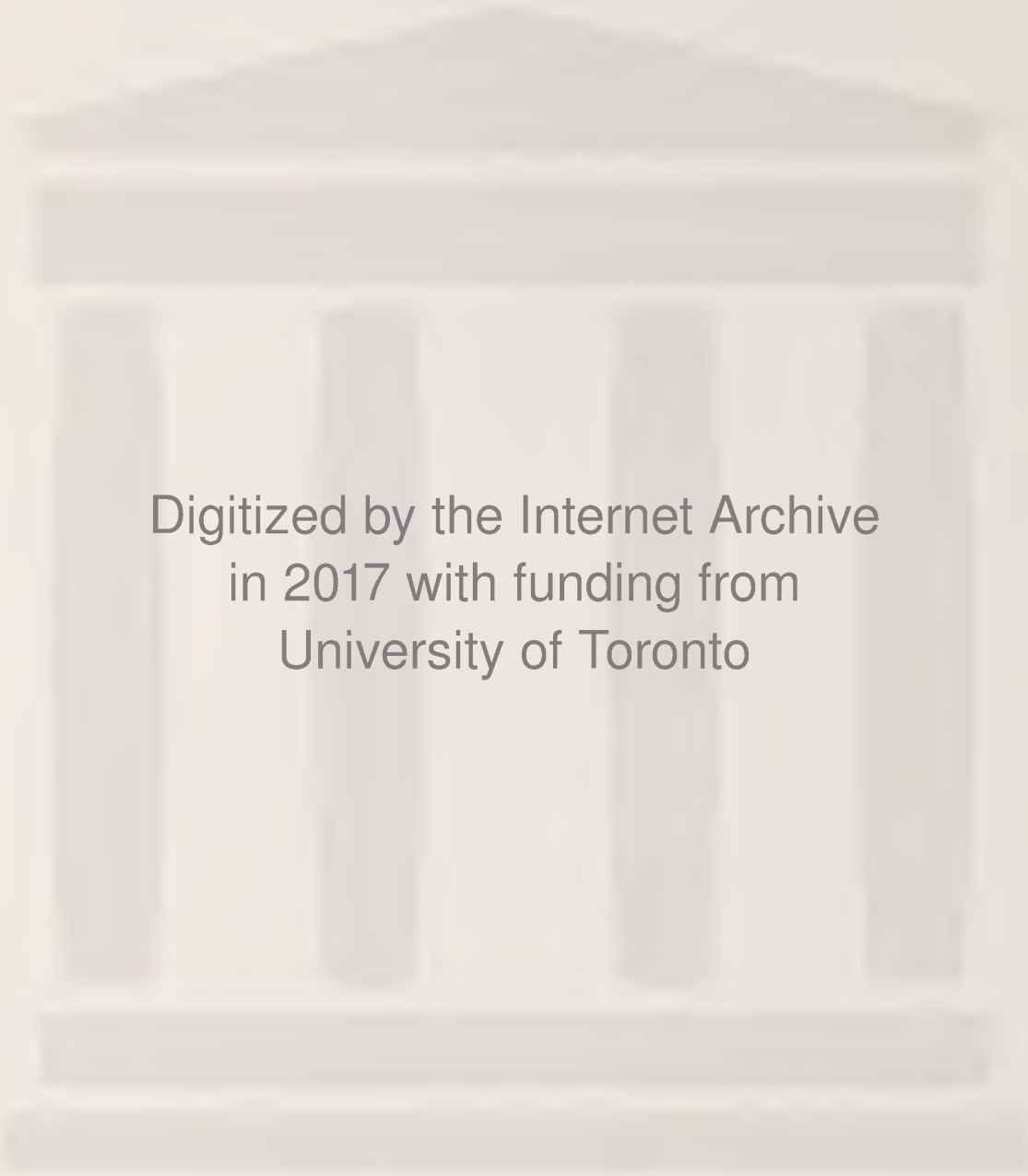
With written contributions from:

Gwen Carroll, Addiction Research Foundation
Virginia Carver, Addiction Research Foundation (Ottawa/Carleton Centre)
Bob Finlay, Addiction Research Foundation (Durham Centre)
Dennis Long, Breakaway Substance Abuse Treatment Centre

Additional consultation provided by:

Helen Annis, Addiction Research Foundation
Maeve Connell, Addiction Research Foundation (London Centre)
Jill Elliot, Grant House
Marion McIntosh, Addiction Research Foundation

TABLE OF CONTENTS



INTRODUCING UNIT 3

Youth workers in the fields of education, mental and physical health, corrections, child welfare, street work, and community work are in an excellent position to recognize the possibility of drug use among their clients, investigate and offer help. It is the goal of this educational package to promote your involvement in that process by providing you with the appropriate knowledge base and necessary skills. In this Unit, we will be focusing on the **identification process**, which is the key to early intervention.

Goals: Unit 3

The goals of Unit 3 are:

- to help you overcome common barriers to the involvement of professionals with young drug users: your own attitudes, the resistance and other obstacles presented by the users themselves, and your concerns about legal issues affecting your work;
- to enable you to recognize young drug users as soon as possible, and place their drug use on a continuum of severity;
- to assist you in analyzing the pattern of their use, in order to develop an action plan to provide either drug education, or assessment and treatment.

We will begin by examining beliefs and attitudes which may be preventing you from becoming involved in the identification process now. Our objective is to promote a set of attitudes that will encourage more professionals to become committed to — and effective in — the provision of assistance to young drug users. Adolescent drug users can be a discouraging group to work with, but their needs should not be ignored.

Then we will describe counselling techniques that are effective with young people. In particular, we will present a key technique for overcoming the resistance and denial of young drug users themselves, an approach known as **motivational counselling**. The ideas of motivational counselling are applicable throughout the counselling process, as part of assessment and treatment as well as identification.

The third Section of the Unit lays out the steps in the identification process itself, and provides the information you need for a pro-active approach to the possibility of drug use among the young people you encounter in your work.

Identification is the first action step you take with someone you suspect to be using drugs. In cases of limited or no drug involvement by your client, it is appropriate to initiate drug education (not the subject of this education package). In cases of greater involvement, it is appropriate to initiate the processes of assessment and then intervention, which are the subjects of Units 4 and 5 respectively.

EXPECTED LEARNING OUTCOMES

When you have worked your way through this Unit, you will be able to:

- ☐ **identify** youth who are in any way involved with drugs;
- ☐ **utilize** direct and straightforward questions to establish drug use parameters;
- ☐ **determine** the nature and severity of a client's drug use problem;
- ☐ **place** a client's drug use on the continuum of drug involvement;
- ☐ **institute** policies and procedures to encourage the voluntary disclosure of drug use by your clients;
- ☐ **corroborate** your observations and views about your client's drug use with significant others in his/her life;
- ☐ **develop** a plan of action for a drug using client, choosing among the following options: on-going monitoring, drug education, drug use prevention and comprehensive assessment;
- ☐ **identify** any attitudes you hold that pose barriers to your work on drug use with an adolescent client group;
- ☐ **list** 6 common myths about drug use in adolescents, and **supply** the correct interpretation;
- ☐ **list** 6 positive attitudes that promote a practitioner's capacity to work successfully in this area;
- ☐ **define** the key concept of client motivation;
- ☐ **name** 4 unhelpful consequences of the mistaken belief that motivation is primarily the client's problem;
- ☐ **list** 6 factors in the client-counsellor relationship that affect client motivation;
- ☐ **name** and **describe** the 4 main stages in the Prochaska and DiClemente model of change;
- ☐ for each of the 4 stages of change, **describe** strategies that you can use to support your client.

After you have completed this Unit, we will ask you to return to this list and check off the learning outcomes you have achieved.

PREVIEW OF TOPICS TO BE COVERED IN UNIT 3

Section 1: ATTITUDES THAT HINDER OR PROMOTE EFFECTIVE COUNSELLING

- negative attitudes
- counsellor personality factors
- assumptions
- moralism
- myths about drug use and its treatment
- positive attitudes

Section 2: COUNSELLING THE ADOLESCENT

- basic counselling
- motivation
- management of disruptive behaviour

Section 3: THE IDENTIFICATION PROCESS

- information gathering
- the continuum of drug involvement
- promoting client disclosure
- objective observation
- deciding on remedial action
- case histories

ESTIMATED WORK TIME AND STUDY TIPS

The estimated study time for this Unit is **15-18 hours**, including the time you will need to watch the episodes of the videotaped case studies and to do the activities. The recommended time reflects the importance we ascribe to this Unit, which is the heart of the Youth and Drugs learning package.

We strongly recommend that you do all activities. Educational research has shown that the active participation of the student in his or her own learning process is more effective than passive reading, in terms of both comprehension and retention. Of course, there may be some that are inappropriate for your needs or situation, and you should use your judgement in selecting the most useful.

Have your VCR and tapes ready

You should begin Unit 3 by viewing the third videotape in your course package. It will take you about 30 minutes. It shows the next episodes in the continuing stories of Cindy, Danny and Theresa, and the professionals who are trying to help them.

To review: in the second episode of the Cindy story, the music teacher, Mr. Peacock, has convinced Daphne Dove that Cindy is showing signs of drug use. He is particularly insistent that Miss Dove interview Cindy in light of the undiscovered drug use of the school's accident victims of the summer. Miss Dove agrees, but she is clearly reluctant.

In the Danny story, Children's Aid worker Pat Gardiner has accompanied street van worker Bill Butler out on his nightly rounds to learn more about drug use among drop-out and runaway youth. Among the youth they meet that night are Mack the Knife, a notorious drug user and minor criminal, who has Danny in tow. After separating Danny from Mack, Bill Butler finds out that he is under age, and sends him home to North Bend.

In the Theresa story, boyfriend Steve has been trying to convince Theresa that her drinking is becoming a problem, at least for their relationship. Theresa disagrees, taking pride in the fact that she has stopped using those drugs that got her into trouble with the law before (primarily cannabis), and insisting that alcohol is different, ordinary, no problem. Probation officer Shelley Oakes has been learning about adolescent alcohol use via a radio program she happens to hear, and through the experiences of a co-worker.

You should turn to your Book of Readings **after** *completing Unit 3.*

Remember that supplementary material on the identification process can be found in your Book of Readings, in the chapter by Margo George and Harvey Skinner. These authors are concerned with assessment as well as identification, so you will probably find it most useful to read this chapter **after** you have finished working through Unit 3 of the Workbook, as a transition to Unit 4.

Questions — Videotape #3

Below you will find the questions raised in videotape #3. There is extra space on the following page for your answers.

"Cindy":

1. How could Daphne have prepared for, and handled, her first interview with Cindy differently?

2. Did you notice how Cindy tried at the outset of the interview with Daphne to signal some of what was really going on in her life? Replay this scene and note down some of her attempts.

3. Cindy claimed to be doing drugs when she wasn't. Why do you think that happened? What factors do you know of in Cindy's life that would lead her to make such a move?

4. What were the strong points in the interview conducted by Collin Cardinal?

"Danny":

1. What are the indicators in the informal assessment interview that Bill Butler conducts on the street that Danny needs further assessment and intervention?

"Theresa":

1. What is your assessment of Shelley's response, once she figures out what's going on with Theresa?

2. Has anything similar ever happened to you? How did you respond?

3. What family dynamics between Carla and her daughter, Theresa, will have to be addressed, before Carla can become a useful ally for Shelley Oakes?

Section 1: ATTITUDES

In any professional relationship, the practitioner's attitudes are a crucial determinant of what happens. In this Section, we will explore the myths, beliefs, personal experiences and personality factors which may colour your attitudes about young drug users, and have an impact on your work with them.

Some professionals are more tolerant of alcohol and drug use in adolescents than in adults, seeing it as a sign of the immaturity and developmental challenge of youth. There is also disturbing evidence that **many professionals are unwilling to become involved in the treatment of youth with drug problems at all.** Research suggests that this reluctance is due to a lack of training and experience, combined with attitudes of intolerance towards abusers. Professionals who have experience in identifying, assessing and treating youth who use drugs, and who receive collegial support, tend to develop positive attitudes toward users. This, in turn, is likely to lead to a greater willingness to identify substance abuse, and more positive outcomes with young drug users.

Many youth workers are untrained to respond to drug and alcohol problems in their clients.

The objective of this Section is to assist you in examining your own attitudes, in order to restructure any which are barriers to effective work with young drug users.

In order to make sure that you are getting the most from this Unit, please turn to page 3-19 and complete ACTIVITY 3.1 before going on with this Section.

1.1 Negative Attitudes

Research tells us that the attitudes of professionals toward alcoholism are little different from those of the general public, and generally negative. The usual finding is that many clergy, physicians, nurses, social workers, and school personnel (among others) view people with alcohol problems as sinful and immoral, weak-willed, unworthy of being helped, and deserving of punishment. The concept that alcoholism is a treatable condition has little resonance for most professionals, who, if they have tried any form of intervention at all, have experienced mostly its failure. They are then likely to generalize their expectation of failure to all types of drug use and interventions.

Biographical Factors

Other, more personal factors may also contribute to negative therapeutic attitudes:

- Professionals who abuse substances themselves may have clouded and distorted judgement in diagnosing substance abuse in adolescents. Or, they

may take on the role of "enabler" for their clients, and reinforce the substance abuse pattern.

- Professionals who have grown up with substance abusing parents and/or relatives may have developed rigid attitudes about drug use. For example, the adult child of an alcoholic (ACOA) who is functioning in the role of a social worker may put pressure on clients to abstain from alcohol based on his/her own family experiences, rather than on a careful analysis of what is best for the youth.

Counsellor Personality Factors

There are several personality factors that may hinder a practitioner's relationship with a young drug user. It is important that you identify factors like these within yourself, and deal with them. Here are a few possibilities:

- **Fear:** a timid professional may retreat from the helping relationship when threatened by defensive hostility or belligerent behaviour in a young drug user, or may retreat from a firm diagnosis when contradicted by other care-givers.
- **Hostility:** an angry professional may lose objectivity and become punitive.
- **Ego-involvement:** an insecure care-giver may be manipulated into destructive personal relationships with clients: e.g. "love" affairs, parental protectiveness, and other inappropriate relationships.
- **Self-rejection, low ego-strength:** a self-rejecting professional with an unhealthy need for approval may try to avoid rejection either by backing away from objective diagnosis, or by rejecting the client first.
- **Personal defensiveness:** defensiveness impairs both perception and clinical judgement, and blocks effective communication.
- **Personal negativism:** negativism directly repels clients, and renders the care-giver incapable of conveying the hope young people need to generate motivation for recovery.

Moralism

A moralistic professional is unable to view young drug users and their symptoms objectively, and sits in judgement on them. S/he purports to know what's right or wrong, good or bad for the youth, and condemns him/her instead of examining his/her problem dispassionately. This attitude is particularly counterproductive with young drug users, who are developmentally likely to be hostile to adult judgements.

Some adolescents may have a moralistic attitude towards their own drug taking, expecting you to join them in condemning their behaviour.

COUNSELLOR'S TIP

Encouraging the young drug user to make a factual exploration of the negative consequences of his/her behaviour as they affect him/herself and his/her life is the way to avoid the trap of moralism.

Assumptions

Much of your behaviour towards adolescents is based on the assumptions you make about them. Making assumptions usually involves **starting from observable facts about another person, developing a theory to explain those facts, and then treating the other person as if the theory is proven.** For example, you might observe that a youth's eyes are bloodshot, and assume that s/he has used cannabis, when in fact s/he simply has hay fever, or has had a sleepless night. Professionals who work with youth commonly make false assumptions based on their appearance, behaviour and lifestyle.

There are three things that you need to remember about making assumptions:

- **Recognize that you probably do it.**
- **Don't treat your assumptions as fact.** However strong your convictions, you can always be wrong.
- **Check out your assumptions.** Using non-judgemental words and a neutral tone, test any conclusions you have drawn with the youth to see whether they are accurate or not.

COUNSELLOR'S TIP

Remember, the objective in counselling is not for the counsellor to be right (and the client wrong), but rather for you to establish communication, build a relationship and help the client develop the capacity to deal more effectively with his/her life.

In order to make sure that you are getting the most from this Unit, please turn to page 3-20 and complete ACTIVITY 3.2 before going on with this Section.

Myths About Drug Use and Its Treatment

There are a host of beliefs and myths about drug use and treatment which, if applied as absolute truths, can adversely affect your identification and response to young drug users. Here we will present some of these misconceptions — and challenge them.

- **"The treatment of drug abuse is a highly specialized field. Professionals who suspect that a youth is using drugs should immediately refer to an addiction specialist for assessment and treatment":**

  Although professionals do require basic education and training in drug use identification, assessment and treatment, effective interventions can be delivered by someone like you without your becoming a "specialist". Indeed, many young drug users are reluctant to go for specialized intervention because they do not perceive themselves as "addicts", do not want to go to the trouble of travelling to distant treatment facilities and/or do not want to develop relationships with new care-givers. For these and other reasons, it is preferable for early stage users to be assessed and treated by a familiar front-line professional, whenever possible.

  In communities where local assessment and referral services exist, you will need to consider the pros and cons of referral versus continuing to counsel the adolescent yourself. Multi-problem youth in particular need a case coordinator or manager to avoid a confusion of services.

This issue is discussed further in Unit 4.

- **"S/he is too young to be hooked, it takes years to become addicted":**

  In fact, the right combination of factors can produce drug dependence in persons as young as 10 or 11 years of age, although this is still relatively rare. The development of drug dependence depends on such factors as:

  - availability of the drug and the nature of the drug itself;
  - the characteristics and personal situation of the drug abuser;
  - environmental pressures.

  A study conducted in 1981 by the National Institute on Drug Abuse (NIDA) found that the age of onset of drug use is decreasing into pre-adolescence, at least in the United States. The result will likely be more pre-adolescent drug abusers. This trend is exacerbated by the wide availability of powerful and highly reinforcing drugs such as cocaine and crack, which take less time to induce dependence than substances like alcohol and cannabis.

In isolated Canadian communities, early addiction is less rare.

- **"Nothing can be done until the drug abuser hits bottom":**

  The disease model of drug abuse asserts that the substance abuser must suffer significant personal losses before s/he will be motivated to give up drug use. Many professionals have interpreted this to mean that they are helpless to effect change until the client "hits bottom".

  The majority of young people who abuse drugs do not "hit bottom" in any absolute sense; more often they are pressured into change by negative events brought on by their drug use. These could be relatively minor (e.g. a frank discussion with a guidance counsellor), or major, such as legal problems, school suspensions, etc. It is usually when the negative consequences of drug use begin to outweigh the perceived benefits that the young abuser will seek assistance.

COUNSELLOR'S TIP

You do not need to stand helplessly by waiting for the young person to "hit bottom". You can actively influence the change process as soon as you become aware of any drug use, by raising the awareness of the client to negative consequences, and using references to authority (e.g. probation officer, school principal) to focus the young drug abuser on the need to deal with problems generated by drug use.

- **"Treatment only works for the highly motivated":**

  In fact, many young people come into treatment because of some external pressure, such as a probation condition, school suspension, withdrawal of privileges by parents, etc. This does not reduce their chance for a positive treatment outcome, provided that the professionals they encounter are willing to accept their "external motivation". Move forward by assisting the client to begin to take personal responsibility for his/her identified problems, whatever they are. Treatment can even be designed to take advantage of external motivation, by requiring the young drug user to modify his/her drug-taking behaviour in order to earn privileges at home, at school, or in the treatment program itself.

Motivation will be discussed at length in Section 2 of this Unit.

- **"Young people with drug and alcohol problems can best be helped by ex-addicts and ex-alcoholics":**

  Most studies show no difference in outcome based on previous drug use by the care-giver or counsellor. His/her training and competence are more important than any previous drug history. Furthermore, young people are not likely to identify with practitioners who are ex-addicts or alcoholics, because they do not perceive themselves as being "like that".

- **"As long as kids are using soft drugs, such as alcohol, marijuana and tobacco, they are unlikely to become addicted, and therefore do not need any kind of intervention":**

  Although it is true that the majority of young people who experiment with drugs do not go on to develop drug dependence, the so-called "soft drugs" present a serious problem in terms of their potential for addiction. There is evidence that both marijuana and tobacco may act as "gateway drugs" for some kids, leading to the use of harder drugs like heroin and cocaine. Early identification and treatment can help prevent this development. Both the research literature and clinical experience suggest that the shorter the drug history, and the less extensive and drug use, the better the chance for a positive treatment outcome.

The shorter the drug history, and the less extensive the drug use, the better the chance for a positive treatment outcome.

In order to make sure that you are getting the most from this Unit, please turn to page 3-21 and complete ACTIVITY 3.3 before going on with this Section.

1.2 Positive Attitudes and Counsellor Behaviour

Cartwright (1980) has identified five categories of positive attitude that are associated with greater practitioner recognition of substance abuse and more successful treatment outcomes:

- the willingness and desire of the professional to work with substance abusers;
- the expectation that it will be rewarding to work with this group;
- a feeling of adequacy about his/her professional knowledge and skills in working with substance abuse;
- a belief that professionals have the right to question young people about their drug use;
- a high level of self-esteem.

If you are to work successfully with the young drug user, you need to develop such positive attitudes. In this section, we will explore the following specific beliefs/attitudes that lead to successful working relationships:

PREVIEW OF POSITIVE ATTITUDES

- It is important to be proactive in screening for substance abuse.
- The earlier a drug problem is identified and addressed, the greater the chances of a successful outcome.
- Being aware of one's values and attitudes towards drug use fosters an objective approach to substance abuse screening.
- The expression of resistance/denial by a youth to the intervention(s) of a professional is a normal response, designed to protect him/her from perceived threats to self-esteem.
- Labels such as "alcoholic" or "druggie" are not useful for the professional or the youth.
- If the presence of a substance abuse problem is established, treat it as a priority within the overall treatment plan.

- **It is important to be proactive in screening for substance abuse.**

  You often have to take the first step. Adolescents who have drug related problems are unlikely to raise the issues of drug use on their own because of fear, shame, hopelessness, etc. Those who are consuming drugs at high risk levels and/or in high risk situations, but who are not yet experiencing obvious negative effects, may not even be aware of the connections between their drug use and their perceived problems. You can **only** ensure that you have identified all risks to health and well being if you initiate a discussion with the youth about his/her substance use. (We will discuss the screening interview in more detail on page 3-40.)

Review the successful screening interviews conducted by guidance counsellor Mr. Cardinal with Cindy, and streetworker Bill Butler with Danny in videotape #3.

- **The earlier a drug problem is identified and addressed, the greater the chances of a successful outcome.**

  As you know, alcohol/drug problems exist on a continuum from experimentation with minimal negative consequences for the youth, to drug dependence with major adverse consequences. You should bring the dangers associated with each step of the continuum of involvement to the attention of a client as soon as possible, regardless of the presence/absence of symptoms. The earlier in the addiction process that a drug problem is identified, the less intrusive and costly is the needed intervention. Successful outcomes (reduction to safe levels or abstinence) are not easily achieved with young people who have a long history of drug involvement and a high level of dependence.

  There is evidence that youth on the low end of the drug involvement continuum can be treated successfully with brief advice and/or appropriate self-help reading materials. A heavily dependent youth, on the other hand, whose drug use has altered his/her lifestyle significantly, may require a more intensive intervention that is intrusive for the client and his/her family, and expensive to the community.

- **It is important to be aware of one's values and attitudes towards drug use in order to foster an objective approach to substance abuse screening.**

  Professionalism can be defined in part as an attitude of respect for the client, combined with objectivity towards his/her problems. The barriers to achieving professionalism when screening for substance abuse have their roots in the negative attitudes outlined earlier.

- **The expression of resistance/denial by a youth to the intervention(s) of a professional is a normal response, designed to protect him/her from perceived threats to self-esteem. It is no different from the resistance encountered to other presenting problems that involve loss of face if admitted to. (Note that denial is often shared or mirrored by the professional.)**

  Resistance/denial by substance abusers has traditionally been viewed as unique to those who are drug dependent. Many professionals use it as an excuse not to intervene, or if intervention is unavoidable, not to persist in helping the client deal with setbacks.

  This professional faint-heartedness is in marked contrast with the attitude care-givers take towards other more socially acceptable presenting problems, such as heart disease and cancer. The resistance/denial presented by client groups with these problems is perceived as an understandable response to a traumatic illness. You should be aware that most forms of

Resistance and denial are further discussed in the Section on client motivation, pages 3-26 to 3-32.

resistance are a natural response to threatening life events. This perspective allows you to examine the role that the resistance plays in a young drug user's life, and develop options for dealing with it constructively.

- **Using labels such as "alcoholic" or "druggie" are not useful for the professional or the client. A description of the client's actual behaviour leads to a more objective and useful analysis.**

  Particularly in the case of young drug users, labelling tends to increase their resistance, and interfere with the task of assisting them to see connections between lifestyle problems and their use of drugs. Your focus in a drug abuse screening interview should be to identify the **dimensions** of drug use, and link them to the **consequences** of drug use. For example, encourage the user to describe his/her life in objective behavioural terms, such as "I'm tired every Monday morning and have difficulty getting up for school." Respond non-judgementally by suggesting a connection between drug use and its consequences, "I wonder if getting stoned on Sundays has anything to do with it?"

- **If the presence of a substance abuse problem is established, treat it as a priority within the overall treatment plan.**

  In severe cases, the drug dependent teenager will be unable to take constructive action towards resolving personal problems until the substance abuse has been addressed. The nature of drug abuse is such that a person's capacity to make sound decisions can be severely impaired. It is often difficult to sort out the underlying causes of the drug abuse until the young person is drug free, and able to think clearly about his/her life and functioning. It is not necessary to "work it all out" before taking action.

In order to make sure that you are getting the most from this Unit, please turn to page 3-22 and complete ACTIVITY 3.4 before going on to Section 2.

ACTIVITY 3.1

Examine the possibility that you hold some stereotyped views of young drug users by following these steps:

1. List about five elements of appearance, behaviour or lifestyle that you associate with young drug users.

2. For each element, try to imagine at least two **alternative** conclusions (besides drug use) which could explain what you see.

3. Evaluate the three explanations you now have for each element (drug use and two others), and say which you think is the most likely.

4. Discuss this exercise with a colleague.

ACTIVITY 3.2

1. Review the videotaped episodes of the "Cindy", "Danny", and "Theresa" stories that you have seen so far. Note any examples of the professionals in these case studies making **unwarranted assumptions**, or demonstrating the impact of counsellor **biographical** or **personality** factors, or **moralism** on their relationships with their clients.

2. Make a list of any of your own personal characteristics, moral positions or assumptions that could get in the way of working effectively with young drug users.

ACTIVITY 3.3

1. Make a list of attitudes and beliefs of yours which were challenged as you read through the first two Units of this package.

2. How will these challenges to previously held beliefs have an impact on your involvement with young drug users?

ACTIVITY 3.4

Support from other professionals has been identified as an important factor in promoting positive attitudes towards working with young drug users. Identify existing and potential sources of collegial support for yourself, and make a plan for accessing these people.

Section 2: COUNSELLING THE YOUNG DRUG USER

In this Section, we will present a quick review of basic counselling skills, a discussion of techniques to increase client motivation, and finally, information on the management of disruptive behaviour.

2.1 Basic Counselling Skills with Adolescents

It is sometimes said that the destiny of a counselling relationship is cast in the first interview. Although this may be an exaggeration, it is certainly true that many young drug users who need help do not come back for a second interview. We will discuss an important set of techniques for encouraging and holding a youth in a therapeutic relationship later in this Section, under the heading "Motivation and Motivational Counselling". However, for those who have little previous training in youth counselling, some more basic concepts may be useful.

One of the reasons it is important to give the matter of counselling technique your consideration is that **it is very difficult for most youth to come forward with their problems, whether about drugs or anything else.** It is part of your job to help them feel safe enough to talk. Most young drug users will be very well defended against disclosure of any kind. They expect disapproval and judgement. You should show neither.

Whatever the main objective of your first interview (from routine processing to crisis intervention), you should consider **relationship-building** as an equal objective. Without basic rapport, you will achieve little. **In the case of the adolescent substance user, it has been suggested that the most effective counselling is based on attention to the client's self-esteem.** To have most impact, you should help the adolescent to feel good about him/herself, by recognizing and building on existing strengths and initiatives.

You must always be concerned about relationship-building.

Many adolescents are surrounded by negative messages which interfere with their ability to seek or accept help. It is vital that you give your client the clear message that s/he will be treated like a person — not like a child, a problem or a patient. Another part of your message should be that the client, as a responsible adult, is in charge of his/her own life, and his/her own future. Many young drug users will alternate between demanding this responsibility and rejecting it utterly, which is a source of confusion you must learn to work with. At the same time, you must be prepared to follow through fully with whatever help you offer. Change is possible, and every client is capable of it. But change is also frightening, and it makes good sense that your client will not be willing to try without adequate support.

In general, you need to be more active, more supportive and more expressive of emotion when working with youth than with adults.

The approach we recommend makes use of basic counselling skills, which you will see displayed at least some of the time by the professionals in the videotapes:

- listening
- paraphrasing
- reflecting feelings back
- summarizing
- probing
- interpreting
- constructive confrontation[1]

As we have said, with an adolescent client, it is especially important that you focus as much on his/her strengths and abilities as on problems, in order to contribute to the critical developmental task of building self-esteem. Some basic strategies for conducting productive interviews with adolescents (whether or not they are using drugs) are as follows:

- Always identify yourself, your role in the agency and the objective of the session.
- Your communication style should reflect warmth, empathy, sincerity, and respect.
- Do not be distracted by the manner of dress, hairstyles or language associated with the adolescent presentation.
- Know what your client likes to be called (s/he may be trying to cast off a childish nickname), and use his/her preferred name often.
- Establish a sense of confidentiality, making clear any exceptions you may have to make. (Confidentiality is discussed later in this Unit.)
- Let the adolescent determine the pace of the interview.
- Ask questions one at a time and wait for the youth's response. **Listen** carefully to what is said, and how it is said.
- At the same time, indicate that you will respond to his/her needs with speed.
- Provide appropriate non-verbal support in the form of eye contact, head nods and so on.
- Speak firmly and clearly, and use common terminology.
- Ensure your responses are factual, objective and worded positively.
- Talk about the positive things you would like to see happening in the young person's life, instead of focusing on what the youth should **not** be doing.
- Increase the youth's sense of self-efficacy by assigning graduated, realizable tasks.
- Do not minimize, or pass judgement upon, his/her self-perceptions.

1 These are basic counselling skills, with which this course assumes you are already familiar. For more details, see the Addiction Counselling Training Manual (Bohm and Macdonald, 1987), and similar reference books.

- Avoid power struggles, which will interfere with the counselling process, and may cause the youth to withdraw from the relationship. Teenagers respond best if they can arrive at their own conclusions.
- Pay positive attention to the behaviours you wish to promote, and withhold attention from the rest.
- Always suggest choices, and demonstrate your own flexibility in discussing and modifying them.
- Once choices have been made, do your best to ensure that the youth experiences the consequences. The basis for most adult behaviour change is the experience of consequences.
- Never promise the youth something that is beyond your power to deliver.

Those who work with adolescents should like and feel at ease with young people. This is not as obvious or as simple to achieve as it may seem, for adolescents are sometimes disturbing and disagreeable, and they may trigger unpleasant memories of the practitioner's own adolescence.

COUNSELLOR'S TIP

When working with a young client, take care to avoid playing either a peer role (false equals) or a surrogate parent's role. Instead, aim to be an advocate for the youth, interceding in support of lifestyle change.

In order to make sure that you are getting the most from this Unit, please turn to page 3-37 and complete ACTIVITY 3.5 before continuing on with this Section.

2.2 Motivation and Motivational Counselling

What Is Motivation?

Motivational counselling is a critical skill at **all** *stages of work with young drug users.*

In traditional addiction counselling with adults, motivation has been defined as a **willingness on the part of the drug user to acknowledge his/her problem, and engage in counsellor-directed efforts to change.** The unfortunate consequence of this definition is that, too often, practitioners have judged motivation by checking a user's willingness to:

- **self-label**, i.e. accept a definition as being "sick" or "addicted";
- **show distress;**
- **express a desire for help;**
- **show dependence** on the counsellor;
- **comply** with the counsellor's directions;
- **agree** with the point of view or diagnosis of the counsellor.

Drug users who do **not** exhibit the above characteristics are often considered to be resistant or "in denial" — in other words, unwilling to acknowledge their "real" problems. In traditional addiction counselling, this lack of motivation is considered to be largely **the user's problem.** Many practitioners — especially those working with youth — have taken issue with this approach, as it leaves no role for the pro-active counsellor. The critics point out that if a counsellor defines lack of motivation as the client's problem **only**, s/he may:

- fail to help him/her work on his/her problems;
- devalue his/her attempts to change;
- harbour and communicate hostile, angry, suspicious and judgemental feelings about him/her;
- become discouraged and depressed about his/her progress and possibilities, and communicate those negative feelings.

This view of motivation gives you much more scope for action.

Recently, motivation been re-interpreted as the product of an **interactive process** that is determined as much by what the counsellor does with the client as what the client brings to the situation. **In other words, the interactional model sees motivation as the result of a two-way communication process.** We have found that this model is much more effective in working with young drug users than the traditional model was.

According to related research, a drug user's motivation to engage in the change process is affected by many things that you, as counsellor, control:

- **time:** the quicker you offer help, the more likely a client is to accept it;
- **distance:** the less distance a client has to travel to see you, the more likely s/he will be to continue contact;
- **respect:** the greater the respect you show to the client, the greater the motivation of the client to return;
- **hostility:** any expression of hostility by the counsellor (even in tone) to the client will decrease client motivation;

- **expectancy (prognosis):** expression by the counsellor of a good prognosis (i.e. "Yes, you can beat this and get better") is likely to increase the client's commitment to treatment;
- **empathy/encouragement:** counsellors who demonstrate strong empathy with the client's situation, who avoid discouragement and confrontation, and who encourage and support the client's efforts will increase his/her motivation. (For an important critique of confrontation as used in traditional addictions work, see Miller, 1989.)

TABLE OF DISCOURAGING/ENCOURAGING BEHAVIOURS

DISCOURAGING	ENCOURAGING
— does not listen attentively	— listens attentively
— focuses on negatives	— focuses on positives
— competing, comparing	— cooperative
— threatening	— accepting
— uses sarcasm and embarrassment	— uses humour and hope
— humiliates	— stimulates
— recognizes only well-done tasks, and improvement	— recognizes effort
— uninterested in feelings	— interested in feelings
— bases worth on performance	— bases worth on just being

Adapted from D. Dinkmeyer and L.E. Lascony (1980). **The Encouragement Book.** *Englewood Cliffs, NJ: Prentice Hall.*

The Process of Change

In the view discussed above, motivation is something one **does**, or works toward, not something a young drug user simply **has**. It involves a cooperative effort by both the user and the counsellor to:

- recognize a problem (drug use or another);
- devise an appropriate strategy for change;
- carry out the strategy.

From this perspective, motivation is an aspect of the general process of **change**. Psychotherapists J.O. Prochaska and C.C. DiClemente have evolved a very helpful model of the change process. They describe it as a **staged process** that people go through to achieve any behavioural or other change. They suggest that each stage is clearly identifiable, and that clients move from one to another in sequence, with the possibility of relapse and re-entry, as in the diagram on the following page:

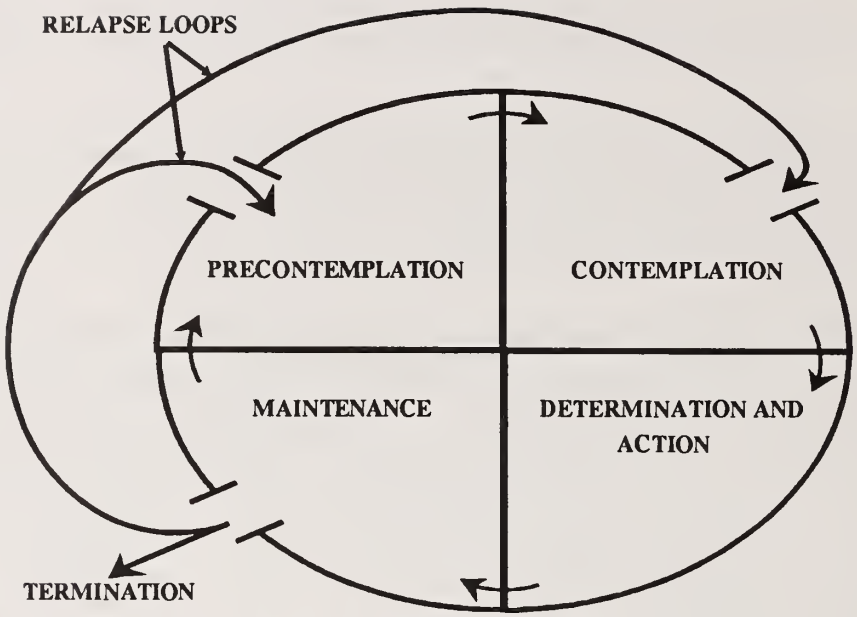


Fig. 3.1: A Stage Model of the Process of Change. *Adapted from James O. Prochaska,* Systems of Psychotherapy: A Transtheoretical Analysis. *(2nd Ed.). The Dorsey Press, Homewood, Illinois, 1984.*

The stages are:

- **Precontemplation:** A young drug user in this stage is not even considering change, for s/he is unaware of any problem. Precontemplators may be:
    - unaware that their behaviour is causing problems for themselves or others;
    - under the illusion that they are immune to the adverse consequences of their actions (i.e. "drug dependence couldn't happen to me").
    - actively resisting or denying the negative consequences of their behaviour, either because the benefits of their behaviour (sociability, acceptance by peers, feeling better, enhanced status and so forth) appear to outweigh the negative consequences, or because an admission of their problem would mean a loss of self-esteem or status.

  Precontemplators are most likely to come to your attention because of the concerns of others, either in the family, or at school or work.

- **Contemplation:** In this stage, young drug users are in a state of ambivalence. It has been called the "yes but" stage, reflecting the fact that part of the youth wants to change, and part does not. S/he may be struggling to understand his/her problems, and is often looking for, or open to, information and guidance from someone like yourself.

  Users often spend a long time in the contemplation stage. Although aware of some problems, they often develop beliefs that reinforce helplessness ("I can't change") or non-responsibility ("if I leave it alone, it will get better on its own").

- **Determination and Action:** Determination is the point at which the balance of indecision tips toward change. In order to achieve this point, several conditions must be met. The youth must:
    - perceive that his/her problems have solutions;
    - believe that s/he is able to make changes;
    - develop a plan of action for change.

  In the action stage, users act on their decisions, and take the first step(s) to change their behaviour. This may mean reducing or stopping drug use, joining AA, working to solve life problems, etc.

- **Maintenance:** This is the most important and difficult stage of change — it's not hard to quit for a day, but it's very hard to keep up that change. The maintenance stage often extends over a long period of time, in serious cases perhaps for the balance of the user's life. Success may require a serious reorganization of the client's lifestyle, and the development of new skills in coping with difficulties and in social and recreational activities.

  It is generally agreed that maintenance does not conclude until the individual experiences no urges or temptations (however mild) to engage in the previous behaviour. At this stage, the client may safely terminate treatment.

We will say more about strategies for maintaining change in Unit 5 on Intervention and Treatment.

- **Relapse:** A return to a previous problematic behaviour is known as a relapse, and may vary from a minor to a major slip. Relapses are frequently triggered by emotional distress, interpersonal conflict, peer/social pressure or other stimuli associated with the problem behaviour.

  In the case of a lapse, or minor slip into the problem, individuals usually have little trouble returning to maintenance. With a more serious return to the problem behaviour (prolapse), a review of options may result in a return to the determination or action stages. In the most serious and extended cases of relapse, the user may revert all the way to the contemplation stage.

For more on relapse and relapse management, see Unit 5, Section 3.4.

Interventions to Support the Process of Change

- **Precontemplation:** In order to help young people in this stage, you should be trying to do two things:
    - "engage", or establish a relationship with the youth;
    - assist the youth in re-evaluating him/herself in terms of life problems.

  In order to build a trusting relationship you should:
    - communicate empathy, warmth, understanding;
    - emphasize that the youth is responsible for and in control of the change process.
    - pay close attention to the youth's presenting problem (the problem that brought him/her to treatment), as the youth sees it;
    - avoid negative labels (alcoholic, drug addict, drug problem, resistant problem, etc).

- use humour, reassurance, limit-setting and similar techniques to instill a sense of confidence, comfort and safety in the youth.

In order to help a young drug user with re-evaluation you should:

- present the work that you and s/he will do as a process of problem identification and solving;
- avoid labelling or value-laden talk;
- examine (together) the perceptions of significant others about the youth's drug use;
- examine with the youth the function of substance use in his/her life;
- relate problems identified by the youth to the use of substances;
- educate the youth in a non-intrusive manner about safe or non-problematic levels of use of substances, if appropriate (caffeine, tobacco, alcohol).

Once the individual has been able to connect his/her drug taking behaviour with the unpleasant consequences, the ground is set for the move to the contemplation stage.

COUNSELLOR'S TIPS

- The transition from Precontemplation to Contemplation is difficult, and must be accomplished by the client. You must be wary of clients who seek to please, placate or avoid conflict with the counsellor by agreeing with your problem definition, without fully accepting or even understanding it.
- This transition may take a very long time. It is essential that you exercise patience, and communicate steady optimism that change is possible for each young drug user.

- **Contemplation:** During the contemplation stage, the youth has to move from acceptance that s/he has a problem to doing something about it. You can assist him/her by:
  - continuing the processes of relationship building and problem identification established in the previous stage;
  - moving to more in-depth work on the problem(s) identified;

- engaging in an examination with the youth of the advantages and disadvantages of overcoming his/her drug related problems;
- exploring the youth's ambivalence to change;
- reviewing possible courses of action, and the positives and negatives of each.

We will discuss these interventions in more depth in Unit 5.

The goal is to help the youth realize that s/he can solve his/her problems (self-efficacy), and that the solutions will lead to an overall improvement in the quality of his/her life (outcome expectation).

- **Determination and Action:** In this stage, the youth has determined to do something about the identified problems. As discussed, this is the stage in which people actually change their behaviour. You can help your client by:
  - helping him/her to set goals for change;
  - helping him/her to select a plan of action most suited to his/her personality, needs, cultural background and preferences;
  - being prepared to support him/her through any barriers to accomplishing his/her actions (e.g. impediments to action, initial fears about change, etc.). Adopt a very pragmatic approach to overcoming these barriers;
  - providing support, encouragement and help in making changes in his/her behaviour.

COUNSELLOR'S TIP

The Action Stage is usually a positive time for young drug users. They often receive enthusiastic support from significant others for making long awaited efforts to change. You can encourage this support, and add your own reinforcement.

- **Maintenance:** In this stage, you can help your client by:
  - providing support and encouragement to the youth in establishing alternative social and recreational activities, friends and support systems;
  - providing guidance and support for the youth in resolving the inevitable interpersonal and familial conflicts that will arise out of his/her change;
  - focusing on the avoidance of relapses to previous behaviour patterns by the above work and by reviewing the gains made in the previous stages.

See Unit 5 for further discussion of strategies for maintenance .

COUNSELLOR'S TIP

Working with young drug users can put you on a roller-coaster of hope and disappointment. Sometimes, the best thing you can do when your best efforts are not working is **let go.** Most adolescents respond badly to pressure, or what they perceive as interference. If you let the youth know that you are there, and that you do believe s/he can make positive changes, this sometimes frees him/her to return to the relationship at another time. It can be a scary step for you, but it often works.

NOTE: The Addiction Research Foundation will be marketing a videotape with supporting text on motivational counselling in 1990.

In order to make sure that you are getting the most from this Unit, please turn to page 3-38 and complete ACTIVITY 3.6 before going on with this Section.

INCREASING CLIENT MOTIVATION: A COUNSELLOR'S TOOL KIT

ADVICE	⇔	Give the client clear and direct advice as to the need for change and how it might be accomplished. Research suggests that a relatively minimal advice intervention is often as effective as extensive treatment in motivating change.
BARRIERS	⇔	Assist the client to overcome basic barriers such as lack of transport, lack of money, physical inaccessibility (for the handicapped), etc.
CHOICE	⇔	Present the client with choices. It is a strong and consistent research finding that people are most likely to persist in a course of action if they have chosen it. It is important to negotiate, not give orders to clients, especially teens.
DECREASING ATTRACTIVENESS	⇔	It is good strategy to help clients become vividly aware of the negative consequences of drug use. Negative imagery or a graphic presentation of the financial costs of continued drug use may be helpful. With children it has been found helpful to teach them to detect and debunk the pro-drug messages in alcohol and tobacco advertising.
EXTERNAL CONTINGENCIES	⇔	Pressure from the outside is often the factor that pushes drug users to seek help, or to change. If conditions and ultimatums are to be used, be sure they can be enforced.
FEEDBACK	⇔	Personal feedback has been found to be more effective than general information about the negative consequences of drug use. It is sometimes useful, for instance, to compare the intake of the client (e.g. of alcohol) with the norms for his/her age group.
GOAL SETTING	⇔	Goal setting has a strong effect on change. Feedback on present problems will have little impact if the client does not recognize it as being discrepant from what s/he wants. Nor is your goal for the client as powerful as his/her own for him/herself.
HELPING ATTITUDE	⇔	The empathetic therapist is the most effective, that is, one who is client-centred, warm and supportive. A hostile, confrontational approach has been found to be associated with more negative long-term results. Small indications of concern, such as a letter or phone call after the initial interview, results in a higher rate of client continuity in treatment. (In one study, the fact that the counsellor rather than the client made the referral call doubled the completion rate.) The professional's expression of optimism is also an important contributing factor.

Adapted from William R. Miller, Increasing Motivation for Change, pp. 70-73 in Reid K. Hester and William R. Miller (Eds.), **Handbook of Alcoholism Treatment Approaches: Effective Alternatives.** *Pergamon Press, New York, 1989.*

2.3 Management of Disruptive Behaviour

When working with adolescent drug users, you always run some risk of encountering intoxication or other disruptive behaviour, which can impede your work. From what we know, there are three principal reasons for young people to be disruptive:

- Many young people have found disruptive behaviour to be more effective in gaining attention from adults than co-operation.
- Others learn to use disruptions as a way of avoiding unpleasant or boring situations.
- Some substances (in some doses) can induce disruptive behaviour in certain users.

When you cannot change a teen's behaviour, try changing your own!

You can prevent, or defuse, many disruptions by modifying (1) the counselling environment you provide, and (2) your response to undesirable behaviour. The latter is the key, since you usually cannot change an adolescent's behaviour by direct confrontation. By changing your own behaviour, you "disturb" the social dynamics between you, which will often lead to a change in the adolescent.

The Environment

There are some simple things to do, and not do, in arranging the physical space in which you see young drug users:

- In case of aggressive outbursts, it is desirable for you, not the youth, to be sitting closest to the door.
- You should not leave articles that could trigger cravings or outbursts sitting in plain sight. This includes glue, corrective fluid, matches, lighters, needles or syringes.
- It is also important to keep potential weapons, such as scissors and letter openers, out of sight. Adolescents are not likely to enter an office with the intention of hurting someone, but the presence of a potential weapon can occasionally cue such an event, as feelings surface during the interview process.

Selective Attention

Granting your attention to a client tends to increase or maintain his/her behaviour, while withholding attention decreases it. That means, if a youth can "get to you" by acting out, chances are that s/he will do it. We know this about two-year-olds, but it is often true of adolescents as well — and it's hard not to get hooked.

Attention includes eye contact, head nods, smiles, frowns, the distance you keep from the adolescent, your physical presence or absence, and all your verbal responses. Privileges, material rewards and punishment are other forms of attention. These are all things you can control.

Before you can effectively apply the selective attention strategy, you must be clear what behaviour it is you want to see. Practitioners are often more able to describe what we don't like in a client than what we would like better. For example, what would you like to see take the place of swearing, threatening or demanding?

The first step is to develop a clear vision of desirable behaviour. Once your vision is set in your mind, **pay attention to the youth's behaviour when it is congruent, and simply disregard the rest.** This is a proven technique for shaping co-operation and discouraging disruptions.

Contingency or Behavioural Contracting

Contingency management is a strategy that lets the youth know, in clear and specific terms, both what is expected of him/her and what will happen if those expectations are or are not met. It can be useful when the youth is uncooperative, demanding, non-compliant or otherwise disruptive. It may take the form of a formal "contract", or just a set of conditions or rules defining your relationship with a particular young drug user.

An effective contract informs the youth what you want him/her to do, what you are prepared to do in return, and when the contingency will be delivered.

To be effective, the rules or contract must be reasonable, and the contingencies must be within your scope of control to deliver. If they are not, you will quickly lose credibility with the youth. As well, contracts, rules and your immediate responses should focus on rewards rather than punishments. For example, it works better to say, "if you stop shouting, I will talk to your science teacher on your behalf" than to say "if you don't stop shouting, I will send you to the vice principal's office"! The idea is that you take no further action until the youth agrees to and fulfils his/her part of the contract.

Substance Induced Behaviour and Intoxication

Substance use affects both the central nervous system (CNS) and the social conduct of the user. There is little you can do to stop CNS effects, such as slurred speech, staggering and incoordination. However, it is usually the associated social conduct that is most disruptive anyway, such as bragging, loudness, swearing and occasional threats. Selective attention and contingency contracting are not as likely to be effective with intoxicated users as with "clean" users.

Refer to Unit 2 for the classifications of common drugs.

If intoxication appears severe, it is important to know whether the youth is in a CNS-stimulated state, a CNS-depressed state, or experiencing distorted perception. If the youth is in a stimulated state, you should reduce stimulants in the environment:

- dim the lights (especially fluorescent lights),
- speak softly,
- control the noise level in the area,
- do not dispense coffee.

On the other hand, if the adolescent is experiencing CNS depression, you may want to increase stimulation in the environment, and serve coffee.

Bill Butler was in this situation with Danny in videotape #3.

If the youth is experiencing distorted perception, s/he needs to be reassured that what s/he is feeling is not real, but the effect of the substance. Stimulation should be reduced (if possible), and if you choose to proceed with the interview, its pace should be kept relaxed.

COUNSELLOR'S TIP

Youth under the influence can and should be held accountable for their behaviour.

ACTIVITY 3.5

Review the first tape in your package. Consider the skills displayed or lacking in Daphne Dove ("Cindy"), the police officer ("Danny") and Shelley Oakes ("Theresa"), and compare them to the lists supplied on page 3-24. In each case, write down two or three things you think they did well, and two or three things you think they did badly.

Daphne Dove:

the police officer:

Shelley Oakes:

ACTIVITY 3.6

1. Think of a behaviour of your own that you have changed or are changing (a bad habit or behaviour problem). Identify the stages you went through or are going through to help achieve this change. Identify the things that helped you to move from one stage to another.

2. Review the videotaped case studies of Cindy, Danny and Theresa. Identify the stage of change that each is in. Suggest ways that you, as practitioner, could help them.

Section 3: THE IDENTIFICATION PROCESS

In this Section, we present the identification of young drug users as a process which involves a variety of investigative actions that will lead you first, to discover whether or not a youth in your jurisdiction uses drugs, second, to determine the extent of that use, and third, to plan the action steps that are needed.

Identification is a process of establishing whether or not a particular young person uses drugs, and determining the nature and severity of the drug use problem. Its purpose is to help you screen out non-users and early stage users (i.e. those who can be helped with preventive education on drugs) from more seriously drug-involved youth who require assessment and treatment. Identification is distinct from, and precedes, assessment. The latter (discussed in Unit 4) is a more comprehensive investigation of a youth's drug use and functioning in other life areas, designed for those whose identified drug use suggests the need for treatment.

We advocate the use of an informal interview process to identify young drug users, rather than simply the administration of screening instruments. Although screening instruments may be a valuable part of your procedure, they are no substitute for the more detailed and intimate process of talking to a young person about drug use.

Identification involves a variety of exploratory actions on your part, actions which should become a routine part of your procedure for getting to know any client. They are:

- asking your client, in a straightforward way, about the extent of his/her involvement in drug use;
- interpreting his/her answers with the aid of your own observations and corroborating evidence that comes from other sources, and drawing conclusions.

The purpose of your actions is to **identify where your client's drug use fits on a continuum of drug use** involvement, and to **determine the corresponding remedial action**. In short, you are trying to identify:

The continuum of drug use will be described on pages 3-37 and 3-38.

- whether or not a youth uses drugs and alcohol, and if s/he does use:
- what is the level of his/her involvement;
- how extensive are the problems or potential problems associated with his/her use;
- what course of remedial action should be undertaken.

THE FIRST STEP is to gather objective information about his/her drug use, using simple screening questions plus your own and others' observations of the youth. **THE SECOND STEP** is to integrate this information, and to match it with the continuum of drug use involvement. **THE THIRD STEP** is to explore the problems and/or potential life problems associated with this person's drug

use, and make a corresponding decision about the course of action needed to remedy the problem(s).

3.1 STEP 1: Gathering Information (Drug Use Profile)

It is sometimes necessary to ease into the topic of drug use slowly, but often the youth is more willing to talk than you are to ask.

All too often, an adolescent's drug use is faced only when serious concerns or crises force the issue. Instead, we strongly recommend that all youth-serving professionals make it a normal practice to ask all clients whether or not they are involved in drug use, and to establish the extent of the drug use, if any. To accomplish this, you should simply ask the youth directly and openly about drug using practices as part of the relationship-building process.

Screening Questions

You can observe the effectiveness of this simple guideline in the interview Colin Cardinal conducts with Cindy, videotape #3.

A professional who demonstrates non-judgemental interest in a client's drug use practices, and who is able to discuss them comfortably and directly, is much more likely to get honest disclosure from his/her clients than the professional who skirts the issue, or who pursues the topic only when suspicions and problems arise. Whether you work informally or in an agency where routine intake questionnaires or interviews are administered, it is relatively easy to incorporate screening questions about drug use into one of your first conversations with a young person.

- A question such as "have you ever used tobacco? alcohol? cannabis? cocaine? (etc.)" will help you establish whether or not the youth has begun to use specific drugs.
- A question such as "how often do you use tobacco (alcohol, cannabis etc.): every day, 2-3 times a week, once a week, once a month, 3 or 4 times a year, once a year, or less?" will help you establish the frequency of use.
- To get an idea of quantity of use, you may ask questions like "in the past month, how many cigarettes did you smoke a day (or week)?" or "how many drinks did you typically have when you drank?"

The first two pages (Domain I) of the DUSI assessment form, pages 4-61, 4-62, could serve as a brief screening tool.

At the identification stage, it is not necessary to do a full assessment of the youth's drug use, but merely to establish whether a more comprehensive assessment of drug use is necessary. In many instances, the screening questions and your own observations yield sufficient information for you to identify where your client's drug use fits on a continuum of drug use involvement. However, in some cases, you will want to instigate a period of observation of the client, and possibly also to contact other people with knowledge of the youth, in order to corroborate what s/he has said and your own observations.

Objective Observations

The following is a list of observations that should cause you to become concerned about the possibility of drug involvement. Note, however, that although these symptoms **may** be indicators of drug or alcohol involvement, some could equally be indicators of other conditions associated with adolescent development, including everything from family conflict to falling in love. Further, neither this list nor any other can be exhaustive of **all** potential symptoms.

- Observations that may indicate recent drug or alcohol use:
  - smell of alcohol, drugs or inhalants
  - unsteady gait
  - inappropriate affect
  - agitation
  - lethargy
  - hyperactivity
  - faintness, passing out
- General observations that may indicate drug or alcohol involvement:
  - accident proneness
  - high level of somatic complaints, health problems
  - legal problems
  - financial problems
  - emotional distress: depression, suicidal ideation or attempts, confusion, mood swings
  - concentration problems
  - sudden weight loss
  - sleep disturbances
  - significant changes in friends, self-care and appearance, school performance, attitude, relationships with significant others.

Corroboration from Collaterals

You may have direct access to collaterals such as family members and other involved professionals (probation officer, school personnel, social worker, etc.), or perhaps to the written records of the professionals. Their observations and concerns about the youth can contribute to your understanding of the situation, especially if there are uncertainties or unanswered questions.

Both their observations and your own can contribute significantly to your preliminary identification of drug use. They are an important means for corroborating what you have learned in direct questioning about your client's drug use practices. However, **observations of client appearance, behaviour and affect should not be your only basis for drawing conclusions about drug use**, or the extent of drug use involvement. They are simply not reliable enough indicators.

This, of course, was the mistake made by Daphne Dove and Percy Peacock, see "Cindy", videotape #2.

To avoid making assumptions about drug use based on observations alone, you should check them out with the youth. If drug use is not at the root of your observations, you will want to know what is.

To conclude STEP ONE, you will need to integrate all that you have learned from your screening questions, your own observations and those from other sources with your knowledge of the presenting problem(s). If you have relatively little information to go on, it may be necessary for you to probe your client further about the circumstances of drug use (alone or in social situations), the effects of the drug use ("how does it make you feel"), and the client's own concerns about the drug use ("are you at all worried about your use of...?").

Policies and Procedures That Promote Client Disclosure

Youth serving agencies and programs should have policies and procedures in place that make it safe for a young person to disclose drug use and any other associated problems.

Ideally we would want young people to be able to self-identify and freely disclose drug use and related problems, whenever they are troubled by them. However, because they have been socialized to assume that drug use will simply "get them into trouble" with adults, young people are understandably reluctant to volunteer information about their drug use. Besides fearing the judgements of the people around them, they may also quite realistically fear disciplinary action. This is especially true in circumstances and settings where there are sanctions for drug use which are punitive: i.e. breach of probation, suspension from school, loss of privileges in the group home or in the family home.

Disclosure of drug-taking should be encouraged with a promise of assistance rather than a threat of punishment.

While we are not suggesting that young people be excused from the consequences of wrongful actions, we do suggest that rules, policies and procedures which are punitive will drive the drug-taking behaviour underground. It is therefore imperative in such settings that there be practices which encourage disclosure with a promise of assistance rather than punishment.

Policies and procedures are required to ensure confidentiality and/or suspend punishment for the youth who is disclosing in order to get help with his/her drug use, or permit him/her to discuss drug use and related problems without having to admit to any violations of rules. It is as important for youth to be aware of the policies and procedures that are designed to help them with a drug use problem as it is for them to know the rules and negative consequences of drug use.

Legal Issues

See the chapter by Solomon and Usprich in your Book of Readings for more on this topic.

Professionals who work with young drug users must understand a youth's right to confidentiality and informed consent, especially where the rights of young clients and those of their parents seem to be in conflict. In many cases of adolescent drug use, parents are the ones to initiate contact with a counsellor, and want to be involved in their child's treatment. It is, therefore, necessary to be clear about the young person's rights in this context.

- **When consent to treatment is required:**

  Generally, consent from the client is required before you initiate any physical examination, test, procedure, surgery, **counselling**, or other interaction. Only in a situation that is life-threatening, and where the youth is unable to provide consent, may you proceed without consent, e.g. if the youth has taken a potentially lethal overdose and is unconscious, very high or incoherent, and consequently unable to provide consent.

COUNSELLOR'S TIP

It might seem that simply by appearing for a counselling appointment, the client has given implicit consent to treatment. However, a young person may be there because of pressure from parents, courts, school, etc., so it is good practice to obtain the young person's written consent to his/her participation in a drug use counselling relationship.

Written consent should be obtained following a full and factual discussion of what the young person may expect to encounter while participating in a particular counselling situation. This not only fulfils the requirement of "informed consent", but can also help to establish a trusting relationship between the young person and the counsellor.

A young person may refuse certain aspects of recommended treatment. You cannot force him/her to participate in a component of your program against his/her wishes, even if such refusal is in violation of other orders, e.g., a probation order.

When a client refuses an element of treatment, the counsellor may decide that the program is not suitable for the client.

- **When is consent valid?**

  In order for consent to treatment to be considered valid, the youth must be competent to provide consent. A young person who is high or intoxicated is probably not competent, and such consent should be postponed until s/he is. Similarly, the consent may not be valid if the youth does not understand what s/he is consenting to, or is misled or deceived about the treatment procedures. For instance, a young person who voluntarily enters an alcohol/drug treatment program, but was not told s/he would be on a locked ward, might claim to have been misled or deceived.

- **At what age is a young person able to give consent, and who else may do it for him/her?**

  Generally, if a young person is considered capable of understanding the proposed treatment, then s/he has the choice to consent or not, regardless of age.

  If the youth is for some reason not competent to give consent, then parents, guardian or next of kin may do so. However, this power must be exercised "in the young person's best interests", which may be difficult to determine. Generally, it is considered that the young person's best interests will be best served by action that improves his/her health or quality of life.

There are specific laws in each province which define the limits of this right of choice, as detailed in Chapter 3 of your Book of Readings.

- **When is the information obtained in the course of a counselling relationship confidential, and under what circumstance may it be disclosed?**

  Information given in the course of a counselling relationship by the client about him/herself, or others such as family members, is confidential and should not be revealed unless the counsellor has permission to do so. Though oral consent is legally sufficient, it is better practice to obtain the youth's consent in writing. The consent form should indicate to whom the information can be released, and be signed and dated, and also dated for use,

meaning that the consent is time-limited and will need to renewed if information is to be disclosed at a later date.

While almost all information obtained in the course of alcohol and drug counselling is confidential, little, if any, is privileged. Under certain circumstances, you can be required to disclose information without the client's consent. It is important that the client be told the circumstances in which the counsellor has to disclose sensitive information received in confidence. Mandatory reporting of child abuse is the most common example. In addition, certain healthcare professionals are required to report a person with a communicable disease to the appropriate public health authority or, in the case of physicians, to report patients whose condition makes it dangerous for them to drive.

COUNSELLOR'S TIP

Some provincial and federal legislation, as well as codes of ethics of various professions, also require that information obtained from clients remain confidential. This means for instance that information obtained from a young person may not be released **even to a parent** without the young person's consent.

Healthcare professionals are **not required to report a criminal offence** that the client reveals during counselling, e.g. possession or trafficking in drugs, prostitution, etc.

The situation is less clear when you believe that a young drug user may be dangerous to him/herself or others; for instance, when suicidal, violent or planning to drive while intoxicated. It is important for your agency to have clear, written policies and procedures, which err on the side of safety, to cover such situations.

You may be required to provide full disclosure when you or your files are subpoenaed by the courts. In this situation, you and your client will be best served if information contained in the files is both complete and objective.

- **Can a professional be charged with possession of drugs or as an accessory to a client's drug-related offence?**

  In the context of alcohol/drug counselling relationships, users may bring in substances and ask their counsellor to dispose of them. It is again important to have clear policies and procedures about how such a situation is to be handled. Generally speaking, the safest course is to ask the youth to flush the substance down the toilet in your presence. Action should be immediate: counsellors who have a substance sitting in their desk drawer for later disposal may be charged with possession!

It is remotely possible that if you counsel a young person to use a less damaging but still illegal drug (e.g. cannabis rather than a narcotic), you could be seen as aiding or abetting a youth to commit an offence. Similarly, though it is appropriate to provide an adult client with strategies to moderate their use of a licit substance, e.g., alcohol, there is a risk in doing the same with a younger under-age drinker. You may face a difficult situation in which a realistic strategy for a particular young person is not entirely legal. The only complete protection you have is not to condone illicit or under-age substance use.

Review the decision taken by Colin Cardinal not to challenge Cindy's admission of under-age drinking. What would you do in this circumstance?

In order to make sure that you are getting the most from this Unit, please turn to page 3-53 and complete ACTIVITY 3.7 before going on with this Section.

3.2 STEP 2: Using Information to Place Client on the Continuum of Drug Involvement

Involvement in drug use can best be viewed on a continuum ranging from **no use** to **dependent drug use**. With youth, the use of a drug usually starts with **experimentation** — and for the vast majority of youth, the use of most drugs does not go beyond the experimental stage. However, use may proceed to **ongoing** but irregular use, **regular** use and finally **dependent** use. An escalating pattern may stop at any step along the way; or it may be different from drug to drug. A particular youth may be **dependent** on tobacco, an **experimenter** with hallucinogens, an **irregular user** of cannabis and a **regular user** of alcohol.

The purpose of identification is to make a preliminary judgement about how to respond to a youth's drug use.

The identification process involves making a tentative or **preliminary** judgement about the level of involvement with the various drugs that a young person is using or has used, based on your screening questions and observations. This will assist you in making a choice among the three courses of action you can take vis-a-vis drug use:

- **continue to monitor,**
- **provide drug use education and prevention counselling,**
- **proceed to a more comprehensive assessment and treatment.**

On the following page is a more detailed description of the stages of the drug use continuum.

STAGES OF THE DRUG USE CONTINUUM

Non-use:	Never used a particular drug.
Experimental use:	Has tried a substance once or several times. Use is motivated by curiosity about the drug effect.
Irregular use:	Use is infrequent and irregular, usually confined to special occasions (holidays, birthdays, etc.) or when opportunities present themselves directly.
Regular use:	Use has a predictable pattern, which may entail frequent or infrequent use. The user actively seeks to experience the drug effect, or to participate in the drug taking activities of the peer group. Usually s/he feels in control of the drug use (i.e. s/he can take it or leave it).
Dependent use:	Use is regular and predictable and usually frequent. The user experiences a physiological and/or psychological need for the drug. S/he feels out of control vis-à-vis its use, and will continue to use despite adverse consequences.

The stages in the continuum cannot be reliably defined in terms of the quantity or dosage of drugs used. However, dosages do give an indication of risk for further involvement along the continuum, and should be considered in determining the course of action to take.

3.3 STEP 3: Deciding on Remedial Action

After you have placed the youth's drug use on the continuum, you must decide on a course of action. You need to consider two things: (1) the potential for adverse effects from current use levels, and (2) the potential for increasing drug use.

Your possible goals for remedial action are:

- to prevent initial involvement in drug use;
- to prevent further involvement in drug use;
- to reverse the involvement in drug use;
- to reduce the actual or potential harm resulting from drug use.

Your options are:

- **Ongoing monitoring:** carry out periodic checks to identify any changes in drug use involvement by re-asking your screening questions;
- **Drug education:** provide factual information about drugs and their effects on health, general well being and legal status. This is best done by means of written material and discussion;
- **Drug use prevention:** promote and reinforce attitudes and behaviours that are incompatible with drug use through discussion, peer counselling, social skills development and other activities.
- **Comprehensive assessment** (followed by a treatment plan): to be discussed in Unit 4.

Wellness promotion with factual information about substance use is required for early stage users.

If your goal is to prevent initiation into drug use, your strategy will include education and prevention activities, and ongoing monitoring. Since many young people are now being exposed to drug education and prevention in their schools, communities and homes, it may be enough for you to reinforce non-use, and to conduct periodic checks on actual use to ensure that you are achieving the goal.

Where would you place Cindy and Danny on the continuum of drug use, and which option for action would you select?

If your goal is to prevent further involvement in drug use, it may also be appropriate to use education and prevention activities, for example with experimental and irregular drug users. This strategy is also likely to reverse the drug involvement of clients who are well-adjusted. In these cases, ongoing monitoring remains important.

In the case of regular drug users, the goal and best course of action will depend on the client's risk status for increased drug involvement, and current problem profile. If the drug use is low and the youth has experienced no detrimental consequences, you may decide to proceed with education and prevention, in order to achieve a goal of preventing further involvement and possibly reversing the existing involvement. On the other hand, if the youth is at risk of increased involvement and has already experienced detrimental consequences, then you may choose to move on to assessment, followed by a treatment plan with a goal of reversing the drug use and reducing consequences.

In cases where you suspect or detect drug use dependence, comprehensive assessment leading to a treatment plan is appropriate.

COUNSELLOR'S TIP

Drug education and prevention initiatives have produced a large body of materials, which this course cannot evaluate. One source which you may find useful is the **Drug Education Resources Directory**, compiled by B.J. Steep for ARF (1989). It comes in five volumes, one listing resources for grades 7-10, and another listing those for grades 11-13.

STAGE OF INVOLVEMENT	GOAL	COURSE OF ACTION
Non-use	— prevent initiation	— reinforce — education & prevention — monitor
Experimental use	— prevent further involvement — reverse involvement	— education & prevention — monitor
Irregular use	— prevent further involvement — reverse involvement	— education & prevention — monitor
Regular use	— prevent further involvement — reverse involvement — reduce consequences	— education & prevention — monitor — assessment
Dependent use	— reverse involvement — reduce consequences	— assessment — treatment

3.4 Case Histories: The Identification of Young Drug Users

1. **Frank** is a 17-year-old high school student. He reports that he smokes about 15 cigarettes daily, drinks 2-4 beers on most Friday and Saturday nights, has used 1-2 joints of cannabis on eight occasions in the past year, and tried acid once.

Please turn to page 3-54 and complete ACTIVITY 3.8, diagnosing the extent of Frank's drug involvement, before going on with this Section.

Discussion: Where Frank Fits on the Continuum

Frank's use of acid can be considered as experimental. His cannabis use (8 times in the past year) might be considered irregular, but you need to determine the **circumstances** of his use to verify this. If he tells you that he only uses with his out-of-town cousin, who is a regular marijuana smoker, and has turned down offers from his other friends, he is certainly an irregular user.

Frank's weekend alcohol use, though regular, does not necessarily indicate dependence. If you observe that he is a competent student, active in sports, athletic and healthy in presentation, friendly and outgoing with you, you will have to seek further information to clarify the matter. Suppose you ask him if he is worried in any way about his drinking, and he states that he (1) avoids getting drunk because he does not like the feeling and effects, and (2) feels he is in control of how much he drinks. If you can corroborate his description, you may conclude that Frank is a regular social drinker.

You already have some evidence that Frank is dependent on nicotine, based on the high frequency and quantity of his daily use of tobacco. In order to determine whether or not there is physical or psychological dependence, you will have to conduct a comprehensive assessment, as discussed in Unit 4.

Discussion: Risk Factors for Frank

Frank's heavy smoking places him clearly at risk for short-term and long-term effects of tobacco on his health. (Review these risks as discussed in Unit 2.) Another indication of risk is his association with other drinkers. The fact that he is under the legal drinking age, and from time to time uses an illegal substance, places him at some risk for legal repercussions. On the other hand, his otherwise healthy lifestyle, positive school adjustment, social relationships, and his ability to refuse drugs and set limits on his drinking should mitigate your concern.

Discussion: Goals for Frank

Suppose that you are Frank's family physician, and he is in your office for his annual check-up. The physical does not reveal any health problems. You make a practice of conducting a drug use screening at each check-up to monitor possible involvement, and you note that he has not increased his use since your last screening interview. You discuss the effects of smoking on his performance in competitive sports, and since he shows an interest in quitting, you give him written material on smoking cessation.

Since he shows no interest in cutting out alcohol, you review the idea of non-hazardous drinking levels. You reinforce the limits that he has set for himself, and his refusal of drug offers from friends.

You discussed the negative health effects of cannabis use at the previous visit, and you now raise a question about whether Frank's cousin may have a cannabis problem. Suppose Frank tells you that the cousin has lost his vitality and energy and has recently dropped out of school, and agrees that he may be dependent on cannabis. You point out that Frank and his cousin are reinforcing each other's use by smoking up when they get together, and explore with Frank what else they might do together that would not involve drug use.

In Frank's case, you are pursuing drug education and prevention, with the goal of preventing further involvement in alcohol use and reducing cannabis and cigarette use. You chose this course of action because Frank is healthy and well-adjusted, with few risks of further involvement and no detrimental consequences of his drug or alcohol use.

2. Susan is a 15-year-old grade nine student. She reports using glue four times, a year ago last summer. Currently, she reports smoking 1-3 cigarettes a day and drinking 4-8 beers four times a month.

Please turn to page 3-55 and complete ACTIVITY 3.9, diagnosing the extent of Susan's drug involvement, before going on with this Section.

Discussion: Where Susan Fits on the Continuum

Susan's use of glue should be considered experimental. Let us suppose that she tells you she smokes only during breaks at school, and she does not use at home or on the weekends for fear her mother will find out. On the basis of this low quantity of use, you may conclude that she is a regular tobacco user, but not yet dependent.

Susan describes a pattern of alcohol use which is regular and predictable. The quantities of her consumption are cause for concern, especially considering her age. Let us suppose that Susan presents as a very shy, unhappy young girl. She is doing poorly in school, skips classes and is considering dropping out as soon as she turns sixteen. Upon further exploration of her alcohol use you learn that she engages in heavy drinking at weekly parties, a pattern which started in high school. She drinks to intoxication on these occasions, claiming that she has more fun and is more fun when she has had a few beers. She could not imagine going to a party without drinking, since it makes her feel part of the crowd. Given this information, you should suspect that Susan is at least psychologically dependent on alcohol.

Discussion: Risk Factors for Susan

Susan's early initiation into drug and alcohol use places her at high risk for further development into a more heavy drug use pattern. This is compounded by her low self-esteem, poor school adjustment and search for peer acceptance through alcohol and cigarette use. Her reliance on alcohol to feel better about herself and to have a good time deprives her of opportunities to develop more healthy life skills. The weekly drinking to intoxication superimposes additional risks to her physical and emotional health. She runs further risks of accidents, breaking the law, promiscuity and unprotected sexual relations. As well, you should be concerned about the apparent lack of support systems such as school, leisure activities and effective parental involvement in Susan's life. She is a high risk user.

Discussion: Goals for Susan

Let us suppose that Susan is being seen by a Children's Aid (CAS) worker. She was in care two years ago for several months while her mother received in-patient treatment for alcoholism. The presenting problem today is that her mother is requesting care again because she has relapsed and needs further treatment. An additional problem is that Susan is pregnant and is undecided about her course

of action. The CAS worker decides to proceed with comprehensive assessment, followed by a treatment plan with a goal of reversing the alcohol use and reducing the detrimental consequences of her use. She has chosen this course of action because despite the drug education and prevention that Susan was exposed to while in care previously, she has increased her involvement in alcohol use and is showing indications of dependence, which is dangerous not only for her but for the fetus if she chooses to continue her pregnancy.

3. **Debbie** is an 18-year-old living on the streets. She reports smoking 5-10 cigarettes a day, taking acid when available — about 10 times in the past year, drinking 2-5 drinks 3 times a week, and using cocaine 3-4 times a week for the past six months.

Please turn to page 3-56 and complete ACTIVITY 3.10, diagnosing the extent of Debbie's drug involvement, before going on with this Section.

Discussion: Where Debbie Fits on the Continuum

Debbie's use of acid appears to be irregular, since she uses only when it is easily available to her, which happens infrequently. Her alcohol use is regular and within the limits of what is considered to be "controlled drinking". However, you have evidence that Debbie is dependent on nicotine, namely the high frequency and quantity of her daily tobacco use.

Debbie's cocaine use is regular and frequent. Given the relatively short period in which dependence on this drug can develop, you should suspect that Debbie is in the dependent stage. If she tells you she works as a prostitute to support her cocaine habit, and additionally you have observed her in a very agitated state on several occasions (when she was coming down from cocaine use), you have good evidence of dependence.

Discussion: Risk Factors for Debbie

Debbie's life on the streets, involvement in prostitution and her drug use pattern place her at very high risk for a wide range of problems. These include heavier involvement in drug and alcohol use, charges for illegal activities, HIV infection, physical and emotional abuse, homelessness. The unresolved problems that precipitated her life on the streets, and the pressures of street life itself, are likely to hold her in a high risk lifestyle until she is able to form a trusting relationship with a worker from the street support services, i.e. street outreach service, drop-in centre, shelter or community health service.

Discussion: Goals for Debbie

Let us suppose that you are a social worker at a shelter for women. Debbie has come to the shelter on several occasions over the past four months for brief stays after fights with her "boyfriend". Although she has not disclosed much about

her life, you suspect that her boyfriend is her pimp, and that he is supplying her with cocaine as well as abusing her physically.

Although your ultimate goal is the assessment and treatment of Debbie's drug use, you will probably have to begin by helping her stabilize her life. Young people who are heavily involved in the street life are unlikely to become engaged in a structured drug treatment process while they remain in that environment.

You would first focus on a goal of harm reduction by helping Debbie to meet her immediate needs of food, safe shelter, and safety. She also needs information on safe sex and needle use. As a trusting relationship develops, you can begin to address the underlying problems: the boyfriend, the drug use and the factors that precipitated her life on the street.

After you have completed this Unit, please turn back to page 3-6 and check off the learning outcomes you have achieved.

ACTIVITY 3.7

1. What policies and procedures are there in your place of work which might inhibit disclosure of drug use?

2. What policies and procedures are in place that encourage the young people you work with to disclose drug use?

3. What policy changes would you recommend in your setting so that disclosure of drug use is made "safer" for the young people you work with?

ACTIVITY 3.8

1. Where would you place Frank's tobacco, alcohol, cannabis and hallucinogen use on the continuum of drug involvement on the basis of your screening of his drug use?

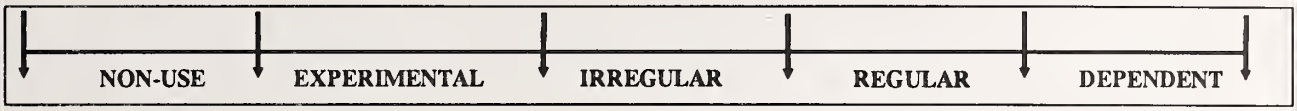
If you have any difficulty placing any of Frank's drug use on the continuum, what additional information would you need to do this, and how would you go about getting it?

2. Identify any factors that might place Frank at risk for:
   - increased involvement in drug use,
   - adverse effects on his health and well being from continued use.

3. State your goals and course of action for Frank.

ACTIVITY 3.9

1. Where would you place Susan's use of inhalants and tobacco on the continuum of drug involvement on the basis of your screening of her drug use?



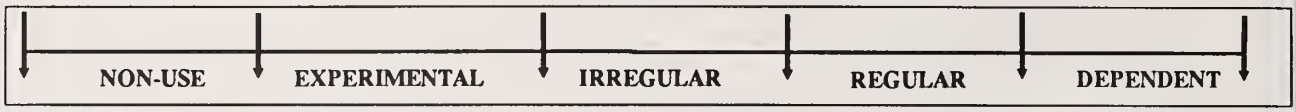
What additional information do you need in order to identify the stage of involvement of her alcohol use, and how would you get it?

2. Identify any factors that might place Susan at risk for:
   - increased involvement in drug use,
   - adverse effects on her health and well being from continued use.

3. State your goals and course of action for Susan.

ACTIVITY 3.10

1. Where would you place Debbie's drug use on the continuum of drug involvement on the basis of your screening of her drug use?



What additional information do you need?

2. Identify any factors that might place Debbie at risk for:
   - increased involvement in drug use,
   - adverse effects on her health and well being from continued use.

3. State your goals and course of action for Debbie.

BIBLIOGRAPHY

Aharan, C.H., Ogilvie, R.D., & Partington, J.T. (1967). Clinical Indications of Motivation in Alcoholic Patients. *Quarterly Journal of Studies on Alcohol, 28*, 486-492.

Berger, E. (1981). Probation and Parole Officers' Perceptions of Alcoholics. (Doctoral Dissertation, Oklahoma State University, 1980). *Dissertation Abstracts International, 42*, 01A.

Bermas, N. (1980). Practitioners' Attitudes Toward Current Conceptions of Alcoholism: Policy Implications for Treatment and Control. (Doctoral dissertation, Brandeis University, 1980). *Dissertation Abstracts International,42*, 01A.

Bohm, P., & MacDonald, K. (1986). *Addiction Counselling Training Manual.* Toronto, ON: Addiction Research Foundation.

Cartwright, A.K. (1980). The Attitudes of Helping Agents Towards the Alcoholic Client: The Influence of Experience, Support, Training and Self-Esteem. *British Journal of Addiction, 75*, 413-431.

Cox, Ann E. (1981). *Training Guidelines and Workbook for the Behavioural Management of Intoxicated and Disruptive Clients.* Toronto, ON: Addiction Research Foundation of Ontario.

Dinkmeyer, D., & Loscony, L.E. (1980). *The Encouragement Book.* Englewood Cliffs, NJ: Prentice Hall.

Kandel, D. (1981). Drug Use by Youth: An Overview. In D.J. Lettieri & J.P. Ludford (Eds.), *Drug Abuse and the American Adolescent* (pp. 1-8). Washington, DC: NIDA.

Koumans, A.J. (1969). Reaching the Unmotivated Patient. *Mental Hygiene, 53*, 298-300.

Lee, B. (1984). The Attitudes of Professionals, Paraprofessionals, Non-professionals Toward Alcoholism and Its Treatment. (Doctoral Dissertation, University of South Dakota, 1983). *Dissertation Abstracts International, 44*, 07B.

Miller, W.R. (1983). Motivational Interviewing With Problem Drinkers. *Behavioural Psychotherapy*, 11, 147-172.

Miller, W.R. (1989). Increasing Motivation for Change. In R.K. Hester & W.R. Miller (Eds.), *Handbook of Alcoholism Treatment Approaches*, (pp. 67-80). Elmsford, NY: Pergamon Press.

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical Therapy: Toward a More Integrative Model of Change. *Psychotherapy: Theory, Research and Practice, 19*, 276-288.

Prochaska, J.O., & DiClemente, C.C. (1984). *The Transtheoretical Approach: Crossing the Traditional Boundaries of Therapy.* Homewood, IL: Dow Jones-Irwin.

Roiter, W.A. (1982). Community Caregivers' and Residents' Perceptions and Attitudes Toward Teenage Alcohol Problems. (Doctoral Dissertation, Boston University School of Education, 1981). *Dissertation Abstracts International, 42,* 07B.

Steep, B.J. (1989). *Drug Education Resources Directory.* Toronto, ON: Addiction Research Foundation.